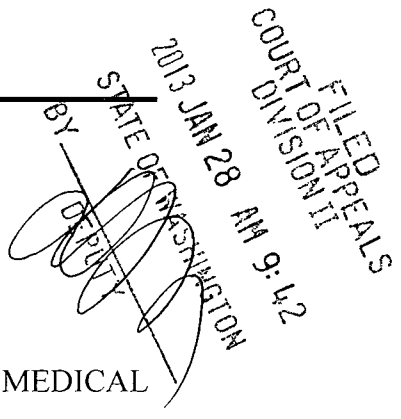
NO. 43552-7

COURT OF APPEALS, DIVISION II
OF THE STATE OF WASHINGTON



LLOYD V. OLSON, M.D.,

Appellant,

v.

STATE OF WASHINGTON, DEPARTMENT OF HEALTH, MEDICAL QUALITY ASSURANCE COMMISSION,

Respondent.

BRIEF OF RESPONDENT

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I. INTRODUCTION

On April 1, 2010, surgical technician Jamie Roy observed something she never expected to see: an anesthesiologist (appellant Dr. Lloyd Olson) fondling two patients before their surgeries began. Several investigations were conducted, and Dr. Olson was charged with professional misconduct by the Medical Quality Assurance Commission (Commission). Following a full hearing on the merits, the Commission determined by clear and convincing evidence that Dr. Olson touched the breasts of two patients, Patients A and B, without any medical justification. The Commission found Jamie Roy credible and Dr. Olson not credible. The Commission's order is fully supported by substantial evidence in the administrative record (AR) before the Court.

II. COUNTERSTATEMENT OF THE ISSUES

1. Should this court adopt a new, heighted standard for reviewing substantial evidence in professional disciplinary cases?

2. Is the Commission's conclusion that Dr. Olson committed unprofessional conduct by intentionally touching the breasts of two unconscious patients without medical justification supported by evidence that is substantial in light of the record as a whole?

3. The Commission made findings of credibility for the two witnesses it found to be material to the dispositive issues in the case. Did

the Commission make sufficient findings of credibility necessary for this Court to affirm?

4. Where the Commission provided Dr. Olson with notice, an opportunity to defend and be represented by counsel, and a show cause hearing followed by a full hearing on the merits, was Dr. Olson afforded due process?

5. Did the Commission apply the applicable sanctions schedules and tiers, and were the sanctions supported by the findings?

III. COUNTERSTATEMENT OF THE CASE

A. The April 1, 2010 Incident

Dr. Olson began working as an anesthesiologist with a practice group called Premier Anesthesia in January 2010. AR 3621. He worked at the Kadlec Medical Center in Richland, Washington. AR 75. On April 1, 2010, he assisted with surgeries performed by Dr. John Droesch, M.D., in operating room 4 by administering anesthesia. AR 195, 3189. Jamie Roy, a surgical technician, and Amber Wissenbach, the circulating nurse, also worked in that operating room (OR) for those surgeries. AR 3185, 3189. Patients A and B were both scheduled for surgery that morning. AR 3189-93, 2356, Finding of Fact (FOF) 1.8.

During the pre-surgery preparations, Ms. Roy observed Dr. Olson fondle the breasts of both Patient A and Patient B. AR 2358, FOF 1.13; 3197-98; 2361, FOF 1.22; 3204-05. His actions occurred after each patient was rendered unconscious, but before they were fully prepped for their respective surgeries. AR 3194-3201, 3204.

1. Patient A

Patient A, a 30 year-old female, had surgery to place a mediport in her chest for use in the chemotherapy treatment of her stage 4 cancer. AR 2356, FOF 1.9.[1] Her surgeon, Dr. Droesch, was very familiar with this patient and had performed at least two prior recent surgeries on her. AR 3511, 3515. Ms. Roy was also familiar with Patient A from discussing her case with Dr. Droesch, and assisting in at least one of her prior surgeries. AR 3191; 3207; 2357-58, FOF 1.12.

Patient A's surgical preparation proceeded as with any other patient, except for Dr. Olson's touching of her breasts. Dr. Olson, as the anesthesiologist assigned to her surgery, met with her outside the operating room to review her history and physicals, confirm her identity, and prepare her for the surgery that was about to begin. AR 3683-90; 4015; 4019; 2357, FOF 1.10. She was then brought into the room and put

[1] A mediport is placed in the soft tissue just below the clavicle (collarbone). AR 3513. A mediport placement is not related in any way to a patient's breast area nor is it a breast procedure. AR 3513.

under anesthesia. AR 3194. Patient A was a very thin woman with small breasts. A visual inspection clearly revealed that she did not have any breast augmentation. AR 3200; 3272; 3512-13; 2357, FOF 1.10. Nevertheless, while Dr. Droesch and Nurse Wissenbach were preparing for the surgery and had their backs to the sleeping patient, Dr. Olson said, "I wonder if she has implants." He then proceeded to place his hands over the breasts of the patient and fondle them for one to two minutes while she was unconscious. AR 3197-98; 4193; 4197-99.

Ms. Roy had completed her preparations for the surgery and was facing the patient with an unobstructed view when she witnessed Dr. Olson's conduct. AR 3197-98; 4193; 2358, FOF 1.13. Dr. Olson later alleged that he touched Patient A's breasts briefly to establish identity. AR 74-78; 3786-87; 4292.

In every surgery, a "time out" or "patient pause" is taken. AR 3208; 3274-75; 3514; 2355-56, FOF 1.6. During this time, all members of the surgical team stop what they are doing and take a moment to ensure that they have the correct patient and are about to do the correct surgery. AR 3274-75; 35-3515; 3736; 2355-56, FOF 1.6. Dr. Olson did not raise any question to any member of the surgical team before he fondled Patient A. Nor did he raise any question during the time out or

otherwise, about the identity of Patient A. AR 3272; 3515-16; 2357, FOF 1.11.

2. Patient B

Patient B, a 58 year-old female patient, was scheduled to undergo a wire-localized breast biopsy. AR 2360, FOF 1.19; 3516-17. She had undergone breast augmentation in the past. AR 2360, FOF 1.20; 3517. The implants were sub-pectoral, meaning they were placed behind the muscle, next to the ribs. AR 3518; 3520; 3551. The fact that her breasts were augmented was obvious by visual inspection. AR 3281; 3203; 4193; 3715; 2360, FOF 1.20. In addition, prior to the surgery, X-rays had been taken of Patient B's breasts and were available in the OR to assist the surgeon in the biopsy. The X-rays clearly showed that she had implants. AR 3525-26; 3557, 2360, FOF 1.19.

As with Patient A, Dr. Olson met with Patient B before rendering her unconscious and had the opportunity then to confirm her identity and review her history and physical information. AR 4100; 2360, FOF 1.20. Hospital staff then brought her into the OR and Dr. Olson placed her under anesthesia. AR 3194. After she was unconscious, while Dr. Droesch and Nurse Wissenbach were completing their preparations for surgery, Ms. Roy observed Dr. Olson place both of his hands over the breasts of Patient B and fondle her for over a minute. AR 3204-05; 4197-99; 4193;

2361, FOF 1.22. Once again, Ms. Roy had a clear, unobstructed view of Patient B and Dr. Olson. She heard Dr. Olson remark something to the effect of, "she has breast implants". AR 3204; 4193; 4198. Once again, Dr. Olson later said that he had been confirming the identity of Patient B. AR 3744; 3922.

Dr. Olson did not question Patient B's identity to any member of the surgical team at the time out or any other time on April 1, 2010. AR 3205; 3282; 3521; 2361, FOF 1.21.

B. The Hospital And Police Investigations

Ms. Roy was shocked and disgusted by Dr. Olson's conduct during the surgical preparation on April 1, 2010, and disclosed her observations the next day to a nurse and then to the hospital's supervising anesthesiologist. AR 3206; 4197-99; 2363, FOF 1.27. On April 9, 2010, Premier Anesthesia and Kadlec Medical Center staff contacted Dr. Olson to obtain his explanation for the events of April 1, 2010. AR 2365, FOF 1.33. On that call, Dr. Olson admitted to touching the breasts of the patients out of curiosity or to determine if they had breast implants. AR 3786-87; 4292. Dr. Olson resigned his position in lieu of termination on April 5, 2010. AR 4290.

Dr. Droesch and hospital staff reported Dr. Olson's conduct and his subsequent resignation to the patients. AR 3531. Patient A then

reported to the Richland Police Department on April 12, 2010. AR 4190. Detective Shepherd from the Richland Police Department investigated her complaint. AR 4190. He interviewed Patients A and B, the involved hospital staff, and then he called Dr. Olson on April 22, 2010. AR 3345-50, 4189-4207 (Detective Shepherd's Report). During that call, Dr. Olson admitted that he had touched the breasts of the patients out of curiosity and that it was a learning experience for him. AR 3353-54; 4194. Detective Shepherd reported the incident to the Commission that day. AR 3837, 3840.

C. The Commission's Investigation And Summary Suspension

The Commission's assigned investigator reviewed Detective Shepherd's report, along with the hospital's investigation report. AR 4333; 2966-69. She provided the information to the Commission and the Commission decided to take immediate action because Dr. Olson posed an immediate danger to the public's health, safety, or welfare. AR 3-6.

On May 4, 2010, the Commission served Dr. Olson with a Statement of Charges, along with a Summary Suspension Order, which immediately suspended Dr. Olson's license. Dr. Olson requested a Show Cause Hearing on the suspension, which was held by telephone on

May 25, 2010. AR 41; 47. The Department[2] provided Dr. Olson the patient records for Patients A and B on May 13, 2010, and the remainder of the investigative file (less privileged documents) on June 3, 2010. AR 1341.

In preparation for the Show Cause Hearing, Dr. Olson filed a Memorandum in Opposition to Summary Suspension of Medical License of Dr. Lloyd Olson (AR 54-71), and a declaration dated May 14, 2010 (AR 74-78). In his declaration, Dr. Olson swore under oath that with regard to Patient A, he had a concern as to whether it was the correct patient for mediport surgery, as well as a concern that the surgeon might damage any breast implants. He admitted that he "pressed on the upper chest of the patient" to determine if implants were present and resolve the discrepancy. AR 74-78. Dr. Olson also admitted in both of these documents to touching the "upper chest wall" of Patient B because he felt her appearance suggested that she did not have implants and he understood from her history that she did have implants. AR 56; 76. He stated that once he detected the implants, his uncertainty was resolved. AR 76. As a result of his declaration statements, whether Dr. Olson was

[2] The Office of the Attorney General prosecutes administrative licensing disciplinary actions like this one on behalf of the Department of Health and each of the various Boards and Commissions. To avoid confusion, the decision maker is referred to as the Commission (or Board when it is a board, or the Secretary in a case that has been delegated to the Secretary), and the prosecution is referred to as the Department.

medically justified in touching the breasts (or chests) of the patients became an issue calling for expert testimony. AR 2332; 74-78.

On May 27, 2010, the Commission ordered that the summary suspension remain in effect. AR 339-44. Dr. Olson then requested an expedited hearing on the merits to be held within 45 days. AR 345.

D. The Commission's Full Evidentiary Hearing

The parties convened for a hearing on the merits on July 8, 9, and 16, 2010. The three day hearing involved extensive witness testimony. AR 2351. The Commission members personally observed the demeanor of each witness, reviewed the exhibits relevant to each witness's testimony, and asked questions of each witness. A brief summary of the testimony of most of the witnesses follows.

1. Testimony of Jamie Roy, Surgical Technician.

Ms. Roy testified that she assisted with both surgeries at issue on April 1, 2010. AR 3189-90; 3201-02. She testified that shortly before Patient A's surgery began, she observed Dr. Olson reach in "with both hands grabbing one hand over each breast and started to fondle her breasts inappropriately". AR 3197. Ms. Roy expressed shock and disgust at what she saw, particularly in light of what the patient had been through medically, and the fact that she was a young mother, like herself. AR 3200; 3191.

When questioned about whether she could have been confused about what patient Dr. Olson touched, Ms. Roy stated there was no confusion and the incident was embedded in her mind. AR 3207; 3247.

Ms. Roy also testified that when Patient B was prepped for surgery, Dr. Olson again "reached down with both hands, one on each breast, and in a massaging motion, cupping her breasts, nipples in his hands, felt her breasts." AR 3204. All of Ms. Roy's testimony at the hearing was consistent with the written account she gave to law enforcement when she first reported the incident to them and what she reported to hospital staff. AR 4197; 4290-91.

2. Testimony of Amber Wissenbach, Circulating Nurse.

Nurse Wissenbach testified that she was in the room at the time of both surgeries, and while she saw Dr. Olson touch the chest of Patient B in a way she did not understand, she did not see the touching as described by Ms. Roy. AR 3283-84; 3315. She also testified that Ms. Roy would have been the person in the best position to have seen such actions, based on her role as a surgical technician (and her need to remain sterile before the surgery) and positioning in the OR. AR 3331.

3. Testimony of Dr. John Droesch, M.D., Surgeon.

Dr. Droesch testified that he did not see Dr. Olson touch either patient inappropriately, but that he would likely have had his back to the

patients and Dr. Olson until the surgery was ready to begin. AR 3545. He gave physical descriptions of the patients and testified that it was obvious that Patient A did not have breast implants and obvious that Patient B did have implants. AR 3513; 3517-18. He testified that Patient B's X-rays, which clearly show that she had implants, were in the room during the surgery. AR 3525-26. Dr. Droesch also testified that Dr. Olson did not raise any issue about identity at the time out for either patient. AR 3516; 3521.

4. Testimony of Detectives Shepherd and Hansens, Richland Police Department.

Detective Shepherd testified that Dr. Olson admitted to him that he touched both patients' breasts as part of his own examination of the patients to satisfy his curiosity and as a learning experience. AR 3354. Dr. Olson told him that as a physician, he was entitled to do his own examination. AR 3354. Detective Hansens corroborated Detective Shepherd's testimony because he had listened to part of the phone call with Dr. Olson. AR 3809.

5. Testimony of Dr. Lloyd Olson, Appellant.

Dr. Olson testified twice during the proceedings. AR 3680-3746; 3883-3963. His testimony was inconsistent with his prior statements to

the investigators and his prior declaration.[3] Contrary to what he said in his May 14, 2010 declaration, Dr. Olson admitted at hearing he was not concerned about the surgeon's scalpel damaging an implant. AR 3702. Dr. Olson claimed his only concern was about the identity of the patients, but conceded that he did not raise any identity issue at the time out for either patient. AR 3738. The other witnesses in the room all testified that nobody raised an issue about the identity of the patients. AR 3515-16; 3521; 3272; 3282.

At the hearing, Dr. Olson conceded he touched the chest of Patient B to determine if she had breast implants. AR 3922; 3744. He asserted that a brief touch was enough to determine that she did have implants. However, the way he describes his touch, he would not have been able to feel Patient B's sub-pectoral implants, he would have only been able to feel her pectoral muscles. AR 3519-20; 2362, FOF 1.24. Dr. Olson testified that he never touched the breasts of Patient A, asserting

[3] Dr. Olson claims the discrepancy was due to not having the medical records before he signed the declaration. Aplt's Br. at 25. However, his attorneys were provided Patient A and Patient B's records before May 14, 2010. AR 3920, 1341. Further, this does not explain all the discrepancies. For example, the justification he gave for touching Patient A's breasts (concern that the surgeon's scalpel in the mediport surgery might damage the implant) would not have been true for Patient 3's mastectomy surgery.

now that he must have touched the chest of a third patient, Patient 3[4], not Patient A. AR 2332; 3703-07.

6. Testimony of Dr. John Ebert, D.O., Expert Witness.

In his defense, Dr. Olson called Dr. Ebert[5] as an expert witness, who testified that it would be acceptable practice for an anesthesiologist to re-examine a patient if he needed to answer a question about whether the correct patient is on the table or whether the correct surgery is about to be performed. AR 3571. However, Dr. Ebert testified that a "time out" or "patient pause" was the more acceptable way to resolve any discrepancies. AR 3582; 3585-86. He also agreed that in regards to Patient B, Dr. Olson could have and should have resolved his concern about the identity by looking at the X-rays that were in the room. AR 3605.

7. Testimony of Dr. Scott Kennard, M.D., Expert Witness.

The Department's expert witness, Dr. Kennard, an anesthesiologist, explained the role and responsibilities of the anesthesiologist. AR 3435-37. He testified that palpating the breasts of a patient as a means of identifying would be "unprofessional conduct at a

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[4] Testimony about Patient 3, whose operation occurred between that of Patients A and B on April 1, 2010, was first introduced into the proceeding by Dr. Olson in support of this defense. Dr. Olson also presented a Supplemental Declaration dated June 17, 2010, that expressed his confusion due to the "three breast surgery patients" that day and recanted his statements in his prior declaration where he admitted to touching Patient A. AR 4359-60.

[5] Dr. Ebert is licensed to practice medicine in North Carolina and South Carolina. He is not licensed in Washington State. AR 4351-58.

minimum if it occurred in my hospital." AR 3443. He further stated that it would never be within the role of the anesthesiologist to palpate a patient's breast. AR 3446. Finally, Dr. Kennard testified that if the anesthesiologist in a surgery had concerns about anything the surgeon was about to do, his or her job is to speak up, not to engage in an examination of the patient. AR 3470-71.

8. Testimony of Dr. Robin Kloth, M.D.

Dr. Kloth, also an anesthesiologist, testified that she could not think of an occasion where it would be appropriate or helpful for an anesthesiologist to palpate a patient's breast. AR 3630.

9. Testimony of Dr. Deeraj Ahuja, M.D.

Dr. Ahuja, also an anesthesiologist, participated on the phone call made by the hospital to Dr. Olson when he was first questioned about the incidents. He testified that Dr. Olson said that he "had every right to examine my patients." AR 3761. He also testified that he could not think of a reason in any situation where an anesthesiologist would have to palpate a patient's breast. AR 3764. Dr. Ahuja also confirmed that the surgical technician would be the first one ready in most surgeries and have no other job to do but observe the room until the surgery begins. AR 3769.

E. The Commission's Final Order

After the July hearing, the Commission deliberated and on September 7, 2010 issued its Findings of Fact, Conclusions of Law, and Final Order (Final Order). AR 2350-73. The Commission determined that Dr. Olson committed unprofessional conduct in violation of RCW 18.130.180(7), WAC 246-919-630, and RCW 18.130.180(24). The Commission found these violations were proven by clear, cogent and convincing evidence. AR 2350-73.

The Commission ordered Dr. Olson's license suspended until he successfully completed the CPEP (Center for Personalized Education for Physicians) evaluation and program in Denver Colorado, including their ProBE course. AR 2368-69 (Final Order 3.1). Once Dr. Olson could prove satisfactory completion of CPEP, his license would be put on Probation for 36 months, with the right to seek modification of the conditions after 24 months. AR 2369 (Final Order 3.2). The conditions of his probation were that he could not touch the breast or breasts of any female patient to which he administers anesthesia except when required to place EKG monitors or similar monitoring devices; annual compliance appearances before the Commission; and that he must provide a copy of the Order to any clinic, group, or hospital where he works, and must have his employer(s) provide letters to the Commission about whether there

have been any complaints about his practice or conduct. AR 2369-70 (Final Order 3.2). There was no fine or other sanction imposed.

IV. ARGUMENT

A. The Standard Of Review Under The Administrative Procedure Act

The Court's review of the Commission's Final Order is governed by the Administrative Procedure Act (APA), RCW 34.05.570. Review is limited to the Commission's Order and the administrative record developed by the Commission. *Blue Mountain Memorial Gardens v. State Dep't of Licensing, Cemetery Board*, 94 Wn. App. 38, 42, 971 P.2d 75, *review denied*, 138 Wn.2d 1011 (1999).

Under the APA, a party challenging the validity of agency action bears the burden of demonstrating its invalidity. RCW 34.05.570(1)(a); *Lang v. Dep't of Health*, 138 Wn. App. 235, 243, 156 P.3d 919 (2007), *review denied*, 162 Wn.2d 1021 (2008). When reviewing an administrative decision, a court acts in a limited capacity and may reverse only if the person challenging the agency order establishes that the order is invalid for one of the reasons specifically enumerated in RCW 34.05.570(3). RCW 34.05.570(1), (3); *Brown v. Dep't of Health*, 94 Wn. App. 7, 11, 972 P.2d 101 (1998), *review denied*, 138 Wn.2d 1010 (1999).

In challenging the Commission's findings, Dr. Olson bears a heavy burden. Under RCW 34.05.570(3)(e), the Commission's findings of fact must be upheld if they are supported by substantial evidence in the record. Substantial evidence is evidence sufficient to persuade a fair-minded person of the truth of the finding. *Heinmiller v. Dep't of Health*, 127 Wn.2d 595, 607, 903 P.2d 433 (1995). This test is highly deferential to the administrative fact-finder. *ARCO Prods. Co. v. Utils. & Transp. Comm'n*, 125 Wn.2d 805, 812, 888 P.2d 728 (1995); *Motley-Motley, Inc. v. State*, 127 Wn. App. 62, 72, 110 P.3d 812 (2005), *review denied*, 156 Wn.2d 1004 (2006). Courts give substantial deference to an agency determination based heavily on factual matters, especially factual matters that are complex, technical, and close to the heart of the agency's expertise. *Hillis v. Dep't of Ecology*, 131 Wn.2d 373, 396, 932 P.2d 139 (1997).

Applying the substantial evidence standard, the reviewing court views "the evidence and the reasonable inferences therefrom in the light most favorable to the party who prevailed." *William Dickinson Co. v. Puget Sound Air Pollution Control Agency*, 81 Wn. App. 403, 411, 914 P.2d 750 (1996). This review "necessarily entails acceptance of the fact-finder's views regarding the credibility of witnesses and the weight to be given reasonable but competing inferences." *Id.* Reviewing courts will

not overturn an agency decision even where the opposing party reasonably disputes the issues and introduces conflicting evidence of equal dignity. *Ferry Cy. v. Concerned Friends of Ferry Cy.*, 121 Wn. App. 850, 856, 90 P.3d 698 (2004), *affirmed*, 155 Wn.2d 824, 123 P.3d 102 (2005). The court does not reweigh the evidence, but instead is limited to assessing whether the evidence satisfies the applicable burden of proof. *Ancier v. Dep't of Health*, 140 Wn. App. 564, 574, 166 P.3d 829 (2007). Unchallenged findings are treated as verities on appeal. *Fuller v. Dep't of Empl. Sec.*, 52 Wn. App. 603, 606, 762 P.2d 367 (1988).

To successfully argue that an agency's order was arbitrary and capricious under RCW 34.05.370(3)(i), Dr. Olson must show that the order is a "willful and unreasoning action, without consideration and in disregard of facts and circumstances. Where there is room for two opinions, action is not arbitrary and capricious even though one may believe an erroneous conclusion has been reached." *Marcum v. Dep't of Soc. & Health Servs.*, ___ Wn. App. ___, 290 P.3d 1045 (2012), citing *State v. Rowe*, 93 Wn.2d 277, 284, 609 P.2d 1348 (1980). Action taken after giving a party ample opportunity to be heard, exercised honestly and upon due consideration, is not arbitrary or capricious. *Washington Med. Disciplinary Bd. v. Johnston*, 99 Wn.2d 466, 483, 663 P.2d 457 (1983). *See also Heinmiller,* 127 Wn.2d at 609-10.

Dr. Olson also alleges error under RCW 34.05.570(3)(a), (c), (d). Review under those subsections is under the "error of law" standard, under which the court may substitute its view of the law for that of the agency, but must give substantial weight to the agency's interpretation of a law within its expertise and to the agency's interpretation of rules it adopted. *Verizon NW., Inc. v. Empl. Sec. Dep't*, 164 Wn.2d 909, 915, 194 P.3d 255, 260 (2008).

Finally, Dr. Olson alleges the Commission did not decide all issues requiring resolution by the agency, under RCW 34.05.570(3)(f). If this court were to agree, the appropriate remedy would be to remand for the Commission to exercise its judgment and make a decision. *Suquamish Tribe v. Cent. Puget Sound Growth Mgmt. Hearings Bd.*, 156 Wn. App. 743, 778, 235 P.3d 812 (2010), *review denied*, 170 Wn.2d 1019 (2011). The court does not substitute its judgment for the agency and decide factual issues on appeal. *Id.*

B. In An Evidentiary Challenge, RCW 34.05.570(3)(e) Requires This Court To Determine Whether The Commission's Final Order Is Supported By Substantial Evidence

The Commission determined that Dr. Olson committed professional misconduct by violating RCW 18.130.180(7) because he violated a state or federal statute or administrative rule, namely, WAC 246-919-630, which states that:

> a physician shall not engage in sexual misconduct with a current patient or key third party. A physician engages in sexual misconduct when he or she engages in the following behaviors with a patient or key third party: (e) Touching breasts, genitals, or any sexualized body part for any purpose other than appropriate examination or treatment.

The Commission also found that Dr. Olson violated RCW 18.130.180(24), which states that unprofessional conduct includes the abuse of a client or patient or sexual contact with a client or patient.

The Commission is required to apply the clear, cogent and convincing standard in making findings of fact in its cases. Appellate courts do not reweigh the evidence or make factual determinations. *State v. Walker,* 153 Wn. App. 701, 708, 224 P.3d 814 (2009). Appellate courts determine only whether factual findings are supported by substantial evidence and, if so, whether the findings in turn support the conclusions of law and judgment. *Nguyen v. Dep't of Health*, 144 Wn.2d 516, 530, 29 P.3d 689 (2001), *cert. denied,* 535 U.S. 904, 122 S. Ct. 1203, 152 L. Ed. 2d 141 (2002). When reviewing findings where the standard of proof is clear, cogent and convincing, "[t]he appellate function should, and does, begin and end with ascertaining whether or not there is substantial evidence supporting the facts as found." *State Farm Fire & Casualty Co. v. Huynh*, 92 Wn. App. 454, 465, 962 P.2d 854 (1998), quoting *Bland v. Mentor*, 63 Wn.2d 150, 154, 385 P.2d 727 (1963).

Dr. Olson asks this court to apply a standard different from the long established "substantial evidence" test. Aplt. Br. at 35. Dr. Olson's exact argument was considered and rejected in *Ancier v. Dep't of Health*, 140 Wn. App. 564, 166 P.3d 829 (2007). In *Ancier*, the court determined that *Nguyen* has no effect upon the standard of review, holding:

> We decline Ancier's invitation to use the Supreme Court's opinion in *Nguyen v. Dep't of Health,* 144 Wn.2d 516, 518, 29 P.3d 689 (2001), as an opportunity to fashion a new and higher standard of review for appeals in medical disciplinary proceedings. *Nguyen* clarified the standard of proof, but does not address the standard of appellate review, which is established by the legislature.

Ancier, 140 Wn. App. at 573, n.12.[6]

Olson relies on *In re Sego*, 82 Wn.2d 736, 513 P.2d 831 (1973), for his argument that something more than substantial evidence should be required, although he does not explain exactly what that something more is. *Sego* was a child custody case involving a parent who murdered his wife; it was not a judicial review of administrative action, and it was not an APA case. *Sego* held that where the state must prove its case by clear, cogent, and convincing evidence, evidence must be more substantial than in the ordinary civil case in which proof is by a preponderance of the

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[6] In fact, rather than moving in the direction of expanding Nguyen as suggested by Dr. Olson, the recent decision in *Hardee v. State, Dept. of Social and Health Services*, 172 Wn.2d 1, 256 P.3d 330 (2011), suggests that the question is really how long and whether *Nguyen* will continue to be good law. Four Justices in *Hardee* would have overruled *Nguyen*.

evidence. *Id.* at 739. However, the *Sego* court did not explain how its "more substantial" evidence standard should be applied. Indeed, Division I declined to follow the *Sego* standard of review in a case involving termination of parental rights:

> The *Sego* court goes on to say, however, that an appellate court may not evaluate credibility or weight of evidence. *Sego,* [82 Wn.2d] at 737–40. Because we cannot envision any means of applying the *Sego* "high probability test" without inexorably passing upon the quality of the evidence, we have chosen to follow the traditional substantial evidence quantitative rule as clearly supported by the rationale of the opinion.

In re Kier, 21 Wn. App. 836, 839 n.1, 587 P.2d 592 (1978).[7] *Accord San Juan County v. Ayer*, 24 Wn. App. 852, 859-60, 604 P.2d 1304 (1979).

This Court "reworded" the *Sego* standard to hold that in parental termination cases there must be evidence from which a rational trier of fact could find the necessary facts by clear, cogent and convincing evidence. *In re Dependency of C.B.*, 61 Wn. App. 280, 286, 810 P.2d 518 (1991). If there is, the evidence is "substantial." *Id. Accord Carle v. McChord Credit Union*, 65 Wn. App. 93, 98, 827 P.2d 1070 (1992).

Dr. Olson includes a one-sentence argument, without citation to authority, that "the separation of powers should preclude the Legislature from dictating the appellate standard of review." Aplt's Br. at 35. In fact,

[7] The court also noted that the two cases relied upon by the *Sego* court in fashioning its revised appellate review standard purported to describe only the trial level burden of proof, not the standard of appellate review. *Kier*, 21 Wn. App. at 839 n.1.

courts' authority to review the Commission's orders is provided exclusively by statute, *see* RCW 18.130.140, RCW 34.05.510, and the bases for providing judicial relief are limited to those in RCW 34.05.570(3). *See Dougherty v. Dep't of Labor & Indus.*, 150 Wn.2d 310, 314 n.1, 76 P.3d 1183 (2003) (under Wash. Const., art. IV, § 6, appellate jurisdiction in the superior courts exists "as may be prescribed by law"). The appellate court sits in the same position as the superior court, applying the provisions of the APA to the record before the agency, and granting relief only in the limited circumstances specified in the APA. *DaVita, Inc. v. Dep't of Health*, 137 Wn. App. 174, 180-81, 151 P.3d 1095 (2007). *Accord Tapper v. Empl. Sec. Dep't*, 122 Wn.2d 397, 402, 858 P.2d 494 (1993).

Finally, as shown in the next section, even under Dr. Olson's proposed new appellate standard of review, the Commission's Final Order is amply supported by substantial evidence of his inappropriate actions.

C. The Commission's Conclusion That Dr. Olson Committed Unprofessional Conduct Rests On Findings Supported By Substantial Evidence In The Record

"[T]he finder of fact is the sole and exclusive judge of the evidence, the weight to be given thereto, and the credibility of witnesses." *State v. Bencivenga*, 137 Wn.2d 703, 709, 974 P.2d 832 (1999). The court views the evidence in the light most favorable to the party who prevailed

in the highest administrative forum to exercise fact-finding authority, and will accept the fact-finder's determinations of witness credibility and the weight to be given to reasonable but competing inferences. *City of Univ. Place v. McGuire*, 144 Wn.2d 640, 652, 30 P.3d 453 (2001).

In health licensing disciplinary hearings, the Commission is "the fact-finder, entitled to weigh the credibility of each witness and determine the weight to give to each opinion, if any." *Ancier*, 140 Wn. App. at 575. A reviewing court gives particularly great weight to findings when credibility and veracity of witnesses are at issue. *In re Discipline of Burtch*, 162 Wn.2d 873, 888, 175 P.3d 1070 (2008). Here the Commission is entitled to deference as it determined the truth from conflicting evidence and gave varying weight to witness testimony. The trier of fact may give to the testimony of any witness such weight and credence as it believes the evidence warrants. *Segall v. Ben's Truck Parts, Inc.*, 5 Wn. App. 482, 488 P.2d 790 (1971). Credibility does not depend on the number of witnesses. In fact, a single witness may be sufficient to present evidence upon which a legally sufficient verdict may be entered. *Segall*, 5 Wn. App. at 483.

1. Witness Jamie Roy's testimony was credible and persuasive; Dr. Olson's testimony was contradictory and not credible.

The Commission specifically found credible Ms. Roy's testimony regarding her observations of Dr. Olson's touching of both Patients A and B's breasts. FOF 1.13, 1.22. Conversely, the Commission found Dr. Olson's denial at hearing that he touched Patient A's breasts not credible. FOF 1.14, 1.17. The Commission also found Dr. Olson's explanation at hearing for why he touched Patient B's breasts was not credible. FOF 1.26. Ms. Roy and Dr. Olson were the key witnesses to his misconduct. Ms. Roy's testimony alone was sufficient for the Commission to reach the conclusion that Dr. Olson committed unprofessional conduct. She was steadfast in what she saw and consistent every time she relayed the information to anyone. She had no motive to lie, and each person she reported to believed her. AR 3627-28.

Ms. Roy is the only person who saw Dr. Olson touching Patients A and B's breasts for a prolonged period of time on April 1, 2010. No other person testified that they could dispute what Ms. Roy observed. They testified only that they did not see the conduct, not that they saw that it did not happen. In fact, the other two people in the room, Dr. Droesch and Nurse Wissenbach, were very busy before each of the surgeries began and

likely had their backs turned when the incidents happened. AR 3331; 3545.

The only person who disputed what Ms. Roy saw was Dr. Olson. However, many of Dr. Olson's statements actually substantiate Ms. Roy's observations. Dr. Olson admitted to Kadlec Medical Center personnel on April 9, 2010, that he had touched the breasts of the two patients out of curiosity. AR 3786-87; 4292. He also made statements to Detective Shepherd on April 22, 2010, that he was a physician and entitled to do his own examination, that it was a learning experience for him, and he had touched the patients out of curiosity. AR 3353-54; 4194. Finally, in his declaration that he signed on May 14, 2010, and filed with the Commission, Dr. Olson again admitted that he touched the "upper chest wall" of Patients A and B to "determine if implants were present." AR 74-78.

Then, at hearing, Dr. Olson denied that he touched Patient A's breasts. He waivered back and forth on whether he touched Patient B's breasts, but claimed if he did, it was for the purpose of identifying if she was the correct patient. He argued that touching the breasts for the purposes of identity was an appropriate examination or treatment. The Commission's finding that he was not credible is supported by the fact that he gave conflicting explanations and justification for his actions leading

up to and during the hearing. The Commission has the authority to determine whether his conduct was "appropriate examination or treatment," and it concluded it was not, even if his touching of the patients' breasts was an attempt to determine their identity, as Dr. Olson claimed.

2. No other witness' credibility was crucial to the findings in this case.

Dr. Olson contends that the Commission should not have relied on one witness, Ms. Roy, and that she was contradicted by numerous other witnesses. Aplt's Br. at 37-40. To the contrary, Ms. Roy's testimony was not contradicted by any other witness, aside from the limited contradiction by Dr. Olson.

Dr. Olson contends that Ms. Wissenbach's testimony contradicted Ms. Roy. Aplt's Br. at 38. However, Ms. Wissenbach testified she saw Dr. Olson touching the chest of Patient A as he adjusted the blankets on her. She does not know if she was seeing a portion of what Ms. Roy saw, or a separate touching altogether. AR 3279. With regard to Patient B, Ms. Wissenbach saw Dr. Olson touching the breast tissue with his fingers. She testified that she did not know why he did and that it did not sound like the same touching that Ms. Roy described. AR 3284.

Ms. Wissenbach further testified that Ms. Roy would have been in a unique position to observe Dr. Olson because once Ms. Roy was set up for the surgery, she had nothing else to do but wait for the procedure to start. AR 3331. Ms. Wissenbach testified that both she and Dr. Droesch would have had multiple jobs to complete before starting the surgery and it was entirely possible that their attention would be turned away from the patient. AR 3331. Dr. Droesch testified that he would likely be working with his back to the operating table before the surgery began. AR 3545.

Dr. Olson contends that Dr. Droesch testified that "if what Roy said was true, he would have seen it." Aplt's Br. at 14, 38. This contention is not supported by the record. Dr. Droesch actually testified, in response to a question about whether it was reasonable that such a touching could have gone on for 90 or 120 seconds without him seeing it, that he thinks he would have seen it if it had gone on for that long. [8] AR 3532-33. He further testified that right before a surgical procedure, his back is to the operating table as he completes paperwork. AR 3545. He was surprised by the allegations, but did not disbelieve them. AR 3544.

[8] The length of time of the touching is not a critical fact. If Ms. Roy incorrectly estimated the length of time (which would be understandable, given her shock at what she was observing), it would still be unprofessional conduct for any such touching to have occurred. AR 3200, 3206; 4197-99; FOF 1.27. Nonetheless, based on her consistency and demeanor at hearing the Commission found her testimony credible. AR 2361, FOF 1.22

Another anesthesiologist who practices at Kadlec, Dr. Ahuja, testified that at the beginning of a procedure, it is entirely possible that something like what Ms. Roy testified to would go unnoticed for 90 seconds. AR 3795. But he was not an eyewitness, so his speculation about what was possible is not what this case hinges upon.

Further, Nurse Wissenbach testified that she did not allow people to remain in the OR if they did not have a job to do. AR 3332. Despite extensive questioning at hearing, no testimony contradicted Ms. Roy's testimony that at the time that Dr. Olson's misconduct occurred, the only people in the OR was the patient on the operating table, Dr. Olson, Dr. Droesch, Nurse Wissenbach, and herself. [9] AR 3224; 3242.

The case thus turned on which of these two witnesses was the most credible: Dr. Olson or Ms. Roy. The other witnesses only provided the context to weigh the credibility of the two material witnesses, as was clearly articulated by Thurston County Superior Court Judge McPhee when he affirmed the Commission's Order at the Judicial Review:

> I think counsel for the Commission got it exactly right when she described the role of the other evidence in the case. It was to understand all of the facts that could surround the events described to determine whether or not the accusation was credible. And if so, then whether it

[9] Dr. Olson tries to place another nurse in the OR at the time that Ms. Roy observed Dr. Olson touching Patient A. Aplt's Br. at 7. However, the nurse had no recollection of being in the OR at that time, and Ms. Roy repeatedly testified that the nurse was not there at the time. AR 3224; 3242.

> constituted a violation of the regulations that govern Dr. Olson's license.
>
> It was not necessary, for instance, to describe the credibility that the Commission gave to the testimony of the surgeon. It was not necessary to determine exactly how the Commission weighed and applied the testimony of the surgeon. What the surgeon testified to was important to understand and make decisions about the credibility of the accusations and the credibility of the denial.

Verbatim Report of Proceedings from April 27, 2012, p. 22.

The Commission believed Ms. Roy and it did not believe Dr. Olson. Its credibility determinations are supported in the administrative record. It was not necessary for the Commission to make any credibility determination for any other person in the operating room, since there was no material testimony that contradicted Ms. Roy, except that of Dr. Olson.

3. Credibility findings were unnecessary as to the testimony of the experts.

Dr. Olson asks this court to remand the final order to the Commission because he claims the Commission was required to make credibility findings for the experts. He claims that because both parties' experts testified that the allegations were unimaginable, credibility findings for these (and all) witnesses were required. Aplt's Br. at 39.

The testifying experts were not called to establish the facts of what occurred in this case. Rather, the experts were called to testify about whether touching a patient's breasts is an acceptable way to confirm their

identity. While Dr. Olson's expert, Dr. Ebert, testified that it was, he also conceded that there were other, better ways to determine identity. AR 3582; 3585-86. Dr. Kennard, the Department's expert, testified that the actions of Dr. Olson, if they occurred, would be unprofessional conduct. AR 3443. Neither of these experts could say whether the actions happened, and there was no need for a credibility finding as to any factual testimony. Instead, this conflicting opinion evidence is exactly the type of issue for which the Commission is entitled to use its knowledge and expertise to determine what the standard of care is, and what constitutes unprofessional conduct by a doctor. *Ames v. Med. Quality Assurance Comm'n,* 166 Wn.2d 255, 261, 208 P.3d 549 (2009); *Washington Med. Disciplinary Bd. v. Johnston,* 99 Wn.2d 466, 663 P.2d 457 (1983).

While it is appropriate for all surgical team members to ensure the identity of the patient on the table, it is not appropriate to fondle their breasts to do so. In the Final Order, the Commission discussed in detail the discrepancy between what Dr. Ebert articulated as the role of the anesthesiologist and what Dr. Kennard described that role to be. AR 2354-56, FOF 1.2-1.7. The Commission concluded the anesthesiologist's role to be as described by Dr. Kennard. In paragraph 1.16 of the Final Order the Commission specifically stated:

> Even if Patient A did have breast augmentation, there is no medical justification to touch Patient A's breasts. The issue whether Patient A had breast augmentation or implants does not affect the Respondent's ability to perform his duties as an anesthesiologist.

AR 2359, FOF 1.6. The Commission further stated, "whether Patient A had breast augmentation cannot address or verify the identity of the patient." AR 2359. The Commission evaluated the testimony of the experts, and based on that testimony, as well as their own experience and expertise, rejected the defense raised by Dr. Olson.

The Commission addressed the same issue (whether there was a medical justification for Dr. Olson to touch the patient's breasts) with regard to Patient B, and rejected the defense raised by Dr. Olson for the same reason: based on the evidence and their own knowledge and expertise, they found there was no medical justification for an anesthesiologist to touch a patient's breasts to verify her identity. AR 2361-63, FOF 1.23, 1.24, 1.25, 1.26.

Dr. Olson mentions Dr. Wheeler's Psychosexual Evaluation Report, Aplt Br. at 30, but fails to clarify that this evidence was admitted only on the issue of sanctions[10], not on the issue of liability. The fact that the Commission did not order Dr. Olson to get another psychosexual

[10] Her report was an attachment to Dr. Olson's sanctions brief. AR 1808-19, 1880-96. Sanctions briefs are provided to the Commission only after they have made a finding of unprofessional conduct.

evaluation indicates only that they likely accepted her findings on that issue. No credibility finding was necessary for the Commission, exercising its expertise, to accept her findings on their merit.

D. Dr. Olson Was Accorded Due Process Throughout This Proceeding

A health professional facing discipline is entitled to due process – meaning notice, an opportunity to be heard, and, in physician discipline cases, the clear, cogent, and convincing burden of proof. *Nguyen,* 144 Wn.2d at 516.

In this case, the Richland Police Department filed a complaint against Dr. Olson with the Commission. Using its normal process, the Commission reviewed the preliminary evidence and authorized an investigation. An investigator was assigned, along with a Reviewing Commission Member to help to direct the investigation. Before any action was taken against Dr. Olson's license, the evidence obtained in that investigation was brought back to the Commission and reviewed by a panel of Commission members.

Against this backdrop—and ignoring the fact that the Commission authorizes disciplinary action, not an investigator—Dr. Olson argues that the Commission's investigator "rushed to judgment," and he equates that characterization to a denial of due process.

Denise Gruchalla, the Commission investigator, initially received the original complaint from the Richland Police Department; a few days later, she received the written statements of Ms. Roy; thereafter, she received the investigating detective's report. AR 3837-38. Both the hospital and the police conducted investigations into the allegations, and Ms. Gruchalla obtained copies of those reports. The Commission reviewed the investigative records Ms. Gruchalla gathered and ordered a summary suspension because they found Dr. Olson presented an immediate danger to the public. AR 4.[11]

When Ms. Gruchalla spoke to the hospital's attorney she advised the attorney that, based on the allegations, the Commission would likely want to act quickly and would probably issue charges in the case based on the information received, and continue the investigation after the case was charged. AR 3861.

As an investigator hired by the Commission, Ms. Gruchalla is not responsible for making the charging decision, drafting the charging documents, or conducting any part of the hearing. AR 3869; 3880-81. Her statements made to a hospital staff member or the hospital's attorney reflect the information she knows at the time, her experience, and her

[11] If the agency finds that public health, safety, or welfare imperatively requires emergency action, and incorporates a finding to that effect in its order, summary suspension of a license may be ordered pending proceedings for revocation or other action. RCW 34.05.422(4).

judgment. They do not constitute a due process violation. Ms. Gruchalla did her job by investigating this case as quickly as possible and forwarding that information to the Commission for the Commission's assessment and determination whether and when to take professional disciplinary action. AR 3862-63.

Ms. Gruchalla was under no legal obligation to re-interview witnesses that the police had already interviewed. She was under no obligation to obtain records for a patient that Ms. Roy did not observe Dr. Olson touching inappropriately.[12] Nothing Dr. Olson argues now supports his position that he was denied a "fair trial in a fair tribunal" (Aplt's Br. at 40) because of Ms. Gruchalla's investigation.

Next, Dr. Olson contends that he did not receive the medical records in this case until one month before hearing and only after a motion to compel. Aplt's Br. at 41. Again, his claim has no merit. The records for the patients charged in the Statement of Charges, Patients A and B, were provided on May 13, 2010, two months before the hearing. AR 1341. Dr. Olson's motion to compel involved records regarding Patient 3. The Department did not have those records at the time of his request. They only became an issue after May 14, 2010, when Dr. Olson

[12] If Dr. Olson's testimony regarding "Patient 3" is believed, then he likely inappropriately touched three patients on April 1, 2010. He offered it to prove he touched Patients B and 3, but not Patient A. AR 3922.

first suggested that he touched Patient 3 on April 1, 2010. Once the Presiding Officer ruled that Dr. Olson could present evidence relating to Patient 3, (conditioned on notice to and no objection from Patient 3), Dr. Olson immediately received those records. AR 1669.

Dr. Olson argues that discrepancies between Ms. Gruchalla's report and the witness statements raise due process concerns. In support of his contention, he cites only the declaration of one of Dr. Olson's attorneys in support of a Motion to Dismiss. Aplt's Br. at 42. He does not cite any place in the record that shows he was prevented or limited in his ability to cross examine the witnesses about any alleged discrepancies at the hearing.

Finally, Dr. Olson argues the alleged "rush to judgment" by Ms. Gruchalla was such that it amounts to arbitrary conduct or governmental misconduct that must be cured by dismissal of the charges. Aplt's Br. at 40-41. He cites *State v. Michielli*, 132 Wn.2d 229, 937 P.2d 587 (1997), for the proposition that his case must be dismissed under CrR 8.3 when there is arbitrary conduct or governmental misconduct, and prejudice to the accused. However, this is not a criminal case, the criminal rules have

no bearing in an APA review,[13] and this case is not at all similar to the facts in *Michielli*. In *Michielli,* the defendant had been charged with theft. Based on the same facts as the theft charge, and apparently without any notice or warning to the defendant, the prosecutor amended the charges in that case five days before trial to add four other charges. That amendment forced the defendant to waive his speedy trial rights in order to prepare for trial.

Dr. Olson's case is distinguishable in many ways. First, it is not a criminal proceeding, so CrR 8.3 does not apply. Second, Dr. Olson does not outline the alleged governmental misconduct or arbitrary conduct committed and by whom. The hospital conducted an investigation, as did the Richland Police Department. Ms. Gruchalla's investigation utilized the reports from those two prior investigations. She then re-interviewed the pertinent witnesses and gathered the pertinent records (including the medical records for Patients A and B), rather than simply relying on the investigations conducted by the other agencies. Patient 3 became an issue

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[13] *See Diehl v. W. Wash. Growth Mgmt. Hearings Bd.*, 153 Wn. 2d 207, 215, 103 P.3d 193, 197 (2004) ("when the legislature adopted the 1988 APA, it expressly chose to break with prior practice and with the Model Act, which provided for an explicit cross-reference to the applicable rules of *civil procedure*"; however, "the legislature specifically authorized the use of *civil rules* in certain sections of the APA, including ancillary procedural matters under RCW 34.05.510(2)"; "we must presume [the legislature] intended the *civil rules* to apply only where specifically authorized (emphasis added)). The court has described the civil rules as "procedural rules, applicable only after the commencement of an action," *id.*, but it has never applied the criminal rules in an APA review.

only after Dr. Olson later raised Patient 3 as a defense. The Department did not amend the charges like in *Michielli,* and investigator Gruchalla did not act unlawfully.

The Commission properly acted to summarily suspend the license of Dr. Olson to protect the public. Dr. Olson received notice of all charges against him and all of the evidence in the possession of the Department that supported those charges. He was provided both a timely show cause hearing and a full hearing on the merits. He was represented by counsel through whom he presented testimony and other evidence and cross-examined adverse witnesses. In sum, Dr. Olson received all the process to which he was due. This court should reject his claim.

E. The Commission Applied The Proper Law To The Facts And The Proper Sanctions Schedules

1. It was not necessary to prove sexual motivation for Dr. Olson's purpose for touching patients' breasts, only that there is no medically appropriate purpose.

"Touching of breasts, genitals or any other sexualized body part for any purpose other than appropriate examination or treatment" is forbidden by WAC 246-919-630. The Department simply had to prove that Dr. Olson had no appropriate examination or treatment purpose to touch the breast of the patients. It was unnecessary to prove what his specific intent was in order to demonstrate unprofessional conduct. There

is nothing in the law to support Dr. Olson's contention that the Department needed to prove sexual motivation as part of its case.

Dr. Olson tried to persuade the Commission that the touching he did was for appropriate examination or treatment. The Commission did not accept his argument on this issue. He could not demonstrate that touching breasts is a proper and medically-accepted way to identify patients, and his defense therefore failed. Had Dr. Olson really questioned whether the correct patients were about to be operated on, there were many other things he could have done to confirm identity, including looking at the patient's wristband, examining the available X-rays, rechecking the paperwork, or consulting with colleagues in the operating room during the routine "time out."

2. The Commission properly applied Tier B from each of the two sanctions schedules in this case.

Finally, Dr. Olson takes issue with the sanction schedules used by the Commission. The Commission imposed a sanction on Dr. Olson that came directly from the applicable sanction schedules adopted by rule in WAC 246-16-820 and WAC 246-16-830.[14] The Legislature mandated that the Commission (and all similar boards and commissions that regulate health professions) use the sanction schedules in all discipline cases.

[14] Sanction schedules are found at WAC 246-16-810 through -860. WAC 246-16-820 and WAC 246-16-830, relevant to Dr. Olson, are attached as Appendices A and B, respectively.

RCW 18.130.390; WAC 246-16-800. There are different schedules for different types of violations: *e.g.*, practice below the standard of care, or sexual misconduct. Within each schedule, there are three tiers, A, B, and C. Tier A is applied to the least serious violations, with the lowest risk of patient harm, and Tier C for the most serious. The sanction schedules help clarify which tier is appropriate in different circumstances. For example, in the schedule for practice below the standard of care, WAC 246-16-810, the box for Tier A applies where the respondent, "caused no or minimal patient harm or risk of minimal patient harm." The box for Tier C of that schedule applies where the respondent, "caused severe harm or death to a human patient."

Dr. Olson appears to believe that the Commission applied the harshest tier of each of the sanctions schedules to Dr. Olson. Aplt's Br at 44. It did not. Two different sanctions schedules were applied based on the findings made by the Commission, and it applied the middle tier—Tier B—from both schedules. AR 2367. Tier B of WAC 246-16-820 was appropriate as it addresses "sexual contact, romantic relationship, or sexual statements that risk or result in patient harm." The sanction range for Tier B is oversight for two to five years which may include suspension, probation, practice restrictions, training, monitoring, supervision,

evaluation, etc. The maximum penalty available under Tier B is revocation.

The Tier B sanction imposed under WAC 246-16-830, which applies to violations under RCW 18.130.180(24), was also appropriate, as it refers to "abusive unnecessary or forceful contact or disruptive or demeaning behavior causing or risking moderate mental or physical harm, including general behavior not directed at a specific patient or patients." The sanction range is identical to Tier B of the sexual misconduct sanction schedule. The Commission found Dr. Olson's touching of the patients to be "forceful contact" because the patients were unconscious and unable to give informed consent for the touching. AR 2367-68.[15] In addition to being forceful contact, Dr. Olson's actions were unnecessary and demeaning, and Tier B is clearly appropriate.

Dr. Olson contends that the Commission imposed "the longest recommended suspension or supervision." Aplt's Brief at 44. In fact, there was no lengthy suspension or supervision ordered. The term of the suspension is dependent upon how quickly Dr. Olson completes evaluations and classes ordered. When he completes the requirements, the

[15] Dr. Olson quotes from Tier C of this schedule, but the Commission clearly applied Tier B here as well. AR 2367. In light of this mistake, it is unclear whether Dr. Olson really has an issue with the part of the sanction schedule that was applied, or if he is just arguing generally that the schedules should not have been used at all, or if he simply misread the schedules.

suspension could be lifted, and his license reinstated with probation imposed for 36 months, with the right to petition for modification after 24 months. AR 2368-70. This sanction actually falls on the low end of Tier B sanctions in the two applied sanction schedules. In contrast, a finding of a Tier C violation would have required a mandatory 1 year suspension of Dr. Olson's license, which did not happen. Dr. Olson has failed to show any error regarding the sanction imposed, much less one that would require this Court to "reverse and dismiss." Aplt's Br at 44-45.

V. CONCLUSION

Dr. Olson fails to meet his burden of demonstrating that the Commission's Final Order is invalid or defective in any way, that the Order is not based on substantial evidence in the record as a whole, that the sanction is outside the appropriate sanction schedule, or that he was denied due process. The Commission respectfully requests that its Final Order be affirmed.

RESPECTFULLY SUBMITTED this 25th day of January, 2013.

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APENDIX A

WAC 246-16-820
Sanction schedule — Sexual misconduct or contact.

SEXUAL MISCONDUCT OR CONTACT (including convictions for sexual misconduct)				
Severity	Tier / Conduct	Sanction Range In consideration of Aggravating & Mitigating Circumstances		Duration
		Minimum	Maximum	
least	A –Inappropriate conduct, contact, or statements of a sexual or romantic nature	Conditions that may include reprimand, training, monitoring, probation, supervision, evaluation, etc.	Oversight for 3 years which may include reprimand, training, monitoring, supervision, evaluation, probation, suspension, etc.	0-3 years
	B – Sexual contact, romantic relationship, or sexual statements that risk or result in patient harm	Oversight for 2 years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, etc.	Oversight for 5 years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, etc. OR revocation.	2 years - 5 years unless revocation
greatest	C – Sexual contact, including but not limited to contact involving force and/or intimidation, and convictions of sexual offenses in RCW 9.94A.030.	1 year suspension AND oversight for 5 additional years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, etc. AND demonstration of successful completion of evaluation and treatment.	Permanent conditions, restrictions, or revocation.	6 years - permanent

[Statutory Authority: RCW 18.130.390. 09-15-190, § 246-16-820, filed 7/22/09, effective 8/22/09.]

APENDIX B

WAC 246-16-830
Sanction schedule — Abuse — Physical and emotional.

ABUSE -- Physical and/or Emotional				
Severity	Tier / Conduct	Sanction Range In consideration of Aggravating & Mitigating Circumstances		Duration
		Minimum	Maximum	
least	A – Verbal or nonverbal intimidation, forceful contact, or disruptive or demeaning behavior, including general behavior not necessarily directed at a specific patient or patients	Conditions that may include reprimand, training, monitoring, probation, supervision, evaluation, etc.	Oversight for 3 years which may include reprimand, training, monitoring, supervision, evaluation, probation, suspension, etc.	0-3 years
	B – Abusive unnecessary or forceful contact or disruptive or demeaning behavior causing or risking moderate mental or physical harm, including general behavior not directed at a specific patient or patients.	Oversight for 2 years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, etc.	Oversight for 5 years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, etc. OR revocation.	2 years - 5 years unless revocation
greatest	C – Severe physical, verbal, or forceful contact, or emotional disruptive behavior, that results in or risks significant harm or death	1 year suspension AND oversight for 5 additional years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, etc. AND demonstration of successful completion of evaluation and treatment.	Permanent conditions, restrictions, or revocation.	6 years - permanent

[Statutory Authority: RCW 18.130.390. 09-15-190, § 246-16-830, filed 7/22/09, effective 8/22/09.]

NO. 43552-7-II

COURT OF APPEALS, DIVISION II
OF THE STATE OF WASHINGTON

LLOYD V. OLSON, MD,

Appellant,

v.

WASHINGTON STATE DEPARTMENT OF HEALTH, MEDICAL QUALITY ASSURANCE COMMISSION,

Respondents.

CERTIFICATE OF SERVICE

I declare under penalty of perjury under the laws of the state of Washington that on January 25, 2013, I served a true and correct copy of the *Brief of Respondent* and this *Certificate of Service* by e-mail and by placing same in the U.S. mail via state Consolidated Mail Service to:

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DATED this 25th day of January, 2013, at Olympia, Washington.

Darla Aumiller
DARLA AUMILLER
Legal Assistant